

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1248

## CERTIFICATE OF DEATH

Reg. Dist. No. 355

### 1. PLACE OF DEATH:

County Worcester  
City or town Ocean City  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 32 years  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State MD County Worcester  
City or town Ocean City  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Samuel Cleveland Adams.

### 3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Evelyn Adams. 6.(c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.) January 12, 1914

8. AGE: Years 32 Months 7 Days 17 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Ocean City Md (Wor. Co.)  
(Town) county, and state

10. Usual occupation night club owner

11. Industry or business \_\_\_\_\_

FATHER 12. Name Archer C. Adams. 13. Birthplace Delaware

MOTHER 14. Maiden name Sadie Cropper. 15. Birthplace Maryland.

16. Informant Mrs. S. C. Adams. Address Ocean City Md.

17. Burial Date thereof 8/31/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Evergreen

Location Berlin Md

18. Funeral director Anna R. Burboe Address Berlin Md

19. 8-31-46 19 Helen F. Hayward  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 29 August 19 46 at 6 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 19 46 to 29 Aug 19 46 and that I last saw him alive on 29 Aug 19 46

Immediate cause of death Acute Dilatation of Heart DURATION 15 min.

Due to Cirrhosis of Liver 2 years.

Due to Decomposed Ulcers Active 2 years.

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)  
Major findings of operations None.

Autopsy results None.  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide None. Date of \_\_\_\_\_

Where did injury occur? None.  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE Thomas R. McCar M. D. or other \_\_\_\_\_

Address Ocean City Md. Date signed 30 Aug 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The is especially important. Physicians: please write the causes of death clearly and legibly

RECEIVED

SEP 3 1946

BUREAU V A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore Md.

## CERTIFICATE OF DEATH

Reg. Dist. No. 350

## 1. PLACE OF DEATH:

County Worcester  
 City or town Pocomoke City  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 3. (a) FULL NAME

Francis E. Bishop

## 4. Sex

Male

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

single

## 6. (b) Name of husband or wife

\_\_\_\_\_ 6. (c) If alive, give age \_\_\_\_\_ years

## 7. Birth date of

deceased (mo., day, yr.)

March 30, 1930

## 8. AGE:

Years	Months	Days	If less than one day
16	4	10	_____ hrs. _____ min.

## 9. Birthplace

Pocomoke, Worcester Md.

## 10. Usual occupation

School boy

## 11. Industry or business

12. Name Frank E. Bishop

## 13. Birthplace

Md.

## 14. Maiden name

Rose De Courvoisier

## 15. Birthplace

Md.

16. Informant Rose De BishopAddress Rural Pocomoke Md.17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Aug 11, 1946Cemetery or crematory Pitts Creek Baptist CemeteryLocation Rural Pocomoke Md.18. Funeral director Henry L. WatsonAddress Pocomoke City Md.19. Aug 10 19 46 Anne E. White

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester  
 City or town Pocomoke City  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

## 2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 8 19 46 at 3:45 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

\_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death

Fractured skull

Due to

Falling off motorcycle

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of Aug 8 '46Where did injury occur? Pocomoke City Worcester Md

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury Fall from motorcycle Injured at work? No23. SIGNATURE John L. Tiley D.D. M.D. ExamAddress Brown Hill (Md) Date signed Aug 8 46

M. D. or other

REGHVEL

AUG 10 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 855

## 1. PLACE OF DEATH:

County WorcesterCity or town near Berlin

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? LifeHospital, institution, or street address where death occurred: noHow long in hospital or institution? no

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WorcesterCity or town near Berlin

(If outside city or town limits, write RURAL and give nearest town)

Street No. no

(If rural, give LOCATION)

2.(a) If veteran, name war no

## 3. (a) FULL NAME

Hester Davis

## 3. (b) Social Security Number

no4. Sex Female5. Color or race col'd6.(a) Single, married, widowed, or divorced widow8.(b) Name of husband or wife William E Davis9. Birth date of deceased (mo., day, yr.) about 18906.(c) If alive, give age no years8. AGE: Years about 56 Months — Days — If less than one day

..... hrs. .... min.

9. Birthplace Berlin Md

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name James Davis13. Birthplace Berlin Md14. Maiden name Rachael Davis15. Birthplace Berlin Md16. Informant Martin DavisAddress Berlin Md RR217. Burial Date thereof Sept-3-46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory EvergreenLocation Berlin Md18. Funeral director James P. StewartAddress Salisbury Md19. 9-3- 19 46 Helen F. Hayward

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 29 19 46 at midnight M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to ..... 19.....

and that I last saw him ..... alive on ..... 19.....

Immediate cause of death myocardial degenerationof heart

Due to.....

Due to.....

Other conditions.....

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DURATION

unknown

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

.....

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE John L. Riley Deputy Mrs EvansAddress Snow Hill Md M. D. or otherDate signed 8/30/46

RECEIVED  
SEP 5 1946  
BUREAU V



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 08457 355

### 1. PLACE OF DEATH:

County WORCESTER.

City or town BERLIN  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 65 YEARS

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County WORCESTER

City or town BERLIN  
(If outside city or town limits, write RURAL and give nearest town)

Street No. TRAPPE  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3.(a) FULL NAME

WILLIAM BORDEN DAVIS

### 3.(b) Social Security Number

4. Sex MALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced MARRIED.

6.(b) Name of husband or wife NORAN DAVIS

6.(c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Nov. 6, 1880

8. AGE: Years 65 Months 9 Days 3 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace BERLIN, MD (TRAPPE)  
(Town, county, and state)

10. Usual occupation MERCHANT

11. Industry or business

12. Name WILLIAM T. DAVIS

13. Birthplace BERLIN, MD.

14. Maiden name CLARA HAMMOND

15. Birthplace BERLIN, MD.

16. Informant MR. RALPH DAVIS

Address BERLIN, MD

17. BURIAL Date thereof 8/12/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory EVERGREEN

Location BERLIN, MD.

18. Funeral director ANNA A. BURBAGE

Address BERLIN, MD.

19. 8-12 46 Helen E. Hayward  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 9 1946 at 4:00P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 7 1946, to Aug 9 1946, and that I last saw him alive on Aug 9 1946.

Immediate cause of death Coronary Occlusion

DURATION 2da.

Due to Generalized arteriosclerosis 20 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results. PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury injured at work?

23. SIGNATURE Spencer, M D M. D. or other Berlin Md  
Address Date signed 8/10/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
AUG 15 1946  
BUREAU V B



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46.2

## CERTIFICATE OF DEATH

Reg. Diat. No. 08458 351

<b>1. PLACE OF DEATH:</b> County..... <u>Worcester</u> City or town..... <u>Giddletown</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... <u>68 years</u> Hospital, institution, or street address where death occurred: ..... How long in hospital or institution?.....				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State..... <u>Maryland</u> County..... <u>Worcester</u> City or town..... <u>Giddletown</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... (If rural, give LOCATION) 2.(a) If veteran, name war.....			
<b>3. (a) FULL NAME</b> <u>Olive G. Rucker</u>				<b>3. (b) Social Security Number</b> <u>none</u>			
<b>4. Sex</b> <u>Female</u>		<b>5. Color or race</b> <u>White</u>		<b>6. (a) Single, married, widowed, or divorced</b> <u>Married</u>			
<b>6. (b) Name of husband or wife</b> <u>Frank J. Rucker</u>				<b>6. (c) If alive, give age</b> ..... <u>69</u> ..... years			
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>July 19 - 1878</u>				<b>8. AGE:</b> Years..... <u>68</u> Months..... <u>1</u> Days..... <u>6</u> If less than one day..... hrs. .... min.			
<b>9. Birthplace</b> <u>Giddletown Worcester Md</u> (Town, county, and state)				<b>10. Usual occupation</b> <u>Homemaker</u>			
<b>11. Industry or business</b> <u>own home</u>				<b>12. Name</b> <u>Charles E. O'Neil</u>			
<b>13. Birthplace</b> <u>Maryland</u>				<b>14. Maiden name</b> <u>Mary E. Bennett</u>			
<b>15. Birthplace</b> <u>Maryland</u>				<b>16. Informant</b> <u>Mr. Frank J. Rucker</u>			
<b>Address</b> <u>Giddletown, Md</u>				<b>17. (Burial, cremation, or removal. Which?)</b> Date thereof..... <u>Aug. 27/46</u> (month) (day) (year)			
<b>Cemetery or crematory</b> <u>Spring Hill</u>				<b>Location</b> <u>Giddletown, Md</u>			
<b>18. Funeral director</b> <u>Clay E. Dennis</u>				<b>Address</b> <u>Snook Hill, Md</u>			
<b>19. (Date rec'd by registrar)</b> ..... <u>8/27/46</u> ..... <u>ReRay Smith</u> Registrar				<b>20. MEDICAL CERTIFICATION</b> <b>2D. DATE OF DEATH</b> ..... <u>August 25</u> 19..... <u>46</u> at..... <u>12:35</u> PM <b>21. I CERTIFY that death occurred on the date above stated; that I attended deceased from</b> <u>January 18</u> ..... 19..... <u>46</u> , to..... <u>Aug 25</u> ..... 19..... <u>46</u> and that I last saw her..... alive on..... <u>Aug 25</u> ..... 19..... <u>46</u> <b>Immediate cause of death</b> <u>Anemia &amp; Cachexia</u> <b>DURATION</b> <u>2 mos</u> <b>Due to</b> <u>Carcinoma of descending Colon with metastases</u> <b>Due to</b> ..... <b>Other conditions</b> ..... (Include pregnancy within 3 months of death) <b>Major findings of operations</b> <u>Carcinoma descending Colon with multiple metastases</u> Date of op. <u>1-26-46</u> <b>Autopsy results</b> ..... <b>PHYSICIAN: Please underline the cause to which death should be charged statistically.</b> ..... <b>22. VIOLENCE: If death was due to external causes, fill in the following:</b> <b>Accident, suicide, or homicide</b> ..... Date of..... <b>Where did injury occur?</b> (City or town)..... (County)..... (State)..... <b>Injured at home, farm, industry, public place (where?)</b> <b>Means of injury</b> ..... <b>Injured at work?</b> ..... <b>23. SIGNATURE</b> <u>Robert L. La Mar, MD</u> M. D. or other <b>Address</b> <u>Snook Hill</u> <b>Date signed</b> <u>8.26.46</u>			

RECEIVED  
AUG 29 1946  
BUREAU V A

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 355

### 1. PLACE OF DEATH:

County Worcester

City or town Ocean City  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 3. (a) FULL NAME

Nellie Hazen Gough

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

married

8. (b) Name of husband or wife Eugene H. Gough

6. (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) October 25, 1874

8. AGE:

Years

Months

Days

If less than one day

71

9

25

hrs.

min.

9. Birthplace Newburgh Indiana  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Darries H. Hazen

13. Birthplace Indiana

14. Maiden name Emma J. Beatley

15. Birthplace Indiana

16. Informant M. E. H. Gough

Address Bornville Indiana

17. Burial Date thereof 8/24/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Maple Grove

Location Bornville Indiana

18. Funeral director Dana B. Burbage

Address Berlin Ind.

19. 8-20 19 46 Helen F. Hayward  
(Date rec'd by registrar) Registrar

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Indiana County

City or town Bornville  
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2. (a) If veteran, name war

### 3. (b) Social Security Number

### MEDICAL CERTIFICATION

20. DATE OF DEATH 20 Aug 1946 at 12:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

On Dec 22, 1945, until On 10/19/46

and that I last saw him alive on 19 Aug 1946

Immediate cause of death Coronary

Thrombosis to

ventricular fibrillation

Due to Myocardial weakness

Due to

Other conditions none

(Include pregnancy within 8 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of

Where did injury occur? None  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury None Injured at work?

23. SIGNATURE Charles P. McE...  
M. D. or other

Address Ocean City Ind. Date signed 20 Aug 46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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AUG 22 1946

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. **353**

### 1. PLACE OF DEATH:

County Worcester  
City or town Bishop, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? life  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester  
City or town Bishop, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Laurence Stall

### 3. (b) Social Security Number

218-20-4222

4. Sex Male 5. Color or race colored 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Aug. 8, 1928

8. AGE: Years 17 Months 11 Days 28 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Seelyville, Del.  
(Town, county, and state)

10. Usual occupation Feed store owner

11. Industry or business \_\_\_\_\_

12. Name Thomas E. Stall

13. Birthplace Friendship, Md.

14. Maiden name E. Esther Whaley

15. Birthplace Berlin, Md.

16. Informant Thos. E. Stall

Address Bishop, Md.

17. Burial Date thereof Aug. 9, 1946  
(Burial, cremation, or removal) Which? (month) (day) (year)

Cemetery or crematory Showell cemetery

Location near Showell, Md.

18. Funeral director Henry S. Watson

Address Pocomoke City, Md.

19. 8/8 46 Rob. Roy Berger  
(Date rec'd by registrar) (year) (month) (day) (signature)

### MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 6 1946, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 25 1946 to Aug 6 1946

and that I last saw him alive on Aug 6 1946

Immediate cause of death \_\_\_\_\_

DURATION

Pulmonary

Due to Haemorrhage.

Pulmonary tuberculosis.

Due to Duration, six months, approx.

Pat's Disease.

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Chas. R. Law M.D. or other \_\_\_\_\_

Address Berlin, Md. Date signed 8-7-46

MARGIN RESERVED FOR BINDING

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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AUG 10 1946  
BUREAU 78



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

08461

Reg. Dist. No. 355

1. PLACE OF DEATH: Worcester  
County.....  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 week  
Hospital, institution, or street address where death occurred:  
.....  
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State..... Beaver  
County.....  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....  
(If rural, give LOCATION)  
2.(a) If veteran, name war..... ✓

3. (a) FULL NAME Joseph Maslinik

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Elsie Maslinik

6. (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Nov. 19, 1879

8. AGE: Years 66 Months 8 Days 27 If less than one day hrs. min.

9. Birthplace Nyrow, Poland (AUSTRIA)  
(Town, county, and state) HUNGARY

10. Usual occupation Retired machinist

11. Industry or business

12. Name Joseph Maslinik

13. Birthplace Austria Hungary

14. Maiden name unknown

15. Birthplace Austria Hungary

16. Informant Mr. Stephen

Address Ambridge, Pa

17. Burial Date thereof 8/20/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Woodlawn

Location Aglipizpa Pa.

18. Funeral director Anna D. Burboze

Address Berlin Md

19. 8-16 46 Helen F. Hayward Registrar

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 16 1946 at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19... to 19... and that I last saw him alive on 19...

Immediate cause of death My ceased degeneration of heart

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John P. Riley D.D., M.D. Exam

Address Snow Hill Md Date signed 8/16/46

RECEIVED

AUG 20 1945

BUREAU V &

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93

## CERTIFICATE OF DEATH

 08462 35  
 Reg. Dist. No.

## 1. PLACE OF DEATH:

County... Worcester  
 City or town... Snow Hill  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 12 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Maryland County... Worcester  
 City or town... Snow Hill  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No...  
 (If rural, give LOCATION)  
 2(a) If veteran, name war... 70

## 3. (a) FULL NAME

Nellie C. Mc Intyre

## 3. (b) Social Security Number

316-09-6121

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife John H. Mc. Intyre

7. Birth date of deceased (mo., day, yr.) Sept. 13 - 1898 8. (c) If alive, give age 43 years

8. AGE: Years 47 Months 11 Days 17 hrs. min.

9. Birthplace Princess Anne, Somerset, Md.  
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

12. Name Susan C. Rydner

13. Birthplace Maryland

14. Maiden name Elizabeth Brittingham

15. Birthplace Maryland

16. Informant Mr. John H. Mc Intyre

Address Snow Hill, Md.

17. (Burial, cremation, or removal, Which?) Burial Date thereof Sept 11/46 (month) (day) (year)

Cemetery or crematory Olmsted near Snow Hill, Md.

18. Funeral director Elmer E. Thomas

Address Snow Hill, Md.

19. (Date rec'd by registrar) 9/11/46 Registrar R. D. Smith

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 1946 at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 18 1941 to Aug 30 1946

and that I last saw him alive on August 30 1946

Immediate cause of death Chronic Degenerative Myocarditis

Due to Rheumatic Fever & Chorea

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Means of injury Injured at work?

23. SIGNATURE Thomas A. Ralston M. D. or other

Address Snow Hill, Md. Date signed Aug 46

RECEIVED  
SEP 3 1946  
BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (85)

## CERTIFICATE OF DEATH

Reg. Dist. No. 08463 354

## 1. PLACE OF DEATH:

County WorcesterCity or town New Stockton  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution? ✓

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WorcesterCity or town Rural Stockton Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Charles Ralph Mishi

## 3. (b) Social Security Number

\_\_\_\_\_

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

6. (c) If alive, give age \_\_\_\_\_ years

## 7. Birth date of

deceased (mo., day, yr.) March 25-1946

## 8. AGE:

Years

Months

Days

If less than one day

423

hrs.

min.

## 9. Birthplace

Wilmington New Castle Del  
(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

12. Name Harry H. Mishi

## 13. Birthplace

Virginia

## 14. Maiden name

Juanita Boston

## 15. Birthplace

Maryland

## 16. Informant

Mrs Juanita Mishi

## Address

Rural Stockton Md.

## 17. Burial

(Burial, cremation, or removal, which?)

## Date thereof

Aug 20 1946  
(month) (day) (year)

## Cemetery

Presbyterian Cemetery

## Location

Brownsville City Md.

## 18. Funeral director

Henry W. Clayton

## Address

Pocomoke City Md.19. Aug 19

(Date rec'd by registrar)

19 thMay M. Taylor

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 18 19 46 at 4:49 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

\_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_

and that I last saw him \_\_\_\_\_

Immediate cause of death

Coronary disease  
to myocardial infarction

DURATION

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? ✓23. SIGNATURE John L. Riley M.D.Dr. H. H. Taylor M. D. or otherAddress \_\_\_\_\_ Date signed 8/18/46

RECEIVED

AUG 31 1946

BUREAU V



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (82a)

## CERTIFICATE OF DEATH

Reg. Dist. No.

08464  
853

## 1. PLACE OF DEATH:

County Monrovia  
 City or town Bishopville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 35 yrs.  
 Hospital, institution, or street address where death occurred: -

How long in hospital or institution? -

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Monrovia  
 City or town Bishopville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. no number  
 (If rural, give LOCATION) -

2.(a) If veteran, name war -

## 3. (a) FULL NAME

William B Morris Sr.

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married8. (b) Name of husband or wife Eva L Morris7. Birth date of deceased (mo., day, yr.) Jan 22 1869 8. (c) If alive, give age 74 years8. AGE: Years 77 Months - Days - If less than one day - hrs. - min.9. Birthplace Delaware  
(Town, county, and state)10. Usual occupation Farmer11. Industry or business -12. Name Arnwell Morris13. Birthplace Del.14. Maiden name Charlotte Brashear15. Birthplace Del.16. Informant W. B. Morris Jr.Address Bishopville, Md.17. (Burial, cremation, or removal. Which?) Burial Date thereof Aug 22 1946  
(month) (day) (year)Cemetery or crematory Del.Location Bishopville, Md.18. Funeral director M. Pasha WatsonAddress Del.19. Aug 22 1946 (Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 17 1946 at 1:00 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 25 1946 to Aug 16 1946 and that I last saw him alive on Aug 16 1946

Immediate cause of death

Cerebral Hemorrhage

DURATION

8 mos.Due to -Due to -Other conditions -

(Include pregnancy within 3 months of death)

Major findings of operations -Date of op. -Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide -Date of -Where did injury occur? -

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) -Means of injury -Injured at work? -23. SIGNATURE Dr. James

M. D. or other

Address Del.Date signed Aug 17 1946

RECEIVED  
AUG 26 1946  
BUREAU V. B.

*J. R. Kelly*  
*J. R. Kelly*  
*J. R. Kelly*

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-8)

## CERTIFICATE OF DEATH

Reg. Dist. No. 08465 357

### 1. PLACE OF DEATH:

County Kor Carter  
City or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 35 years  
Hospital, institution, or street address where death occurred:  
R.D. #1  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State MD County Kor Carter  
City or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. R.D. #1  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Emma Louisa Neuman

### 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or wife Gust Ernst Neuman  
8. AGE: Years 72 Months 6 Days 26 If less than one day  
7. Birth date of deceased (mo., day, yr.) Feb. 13<sup>th</sup> 1874 8. (c) If alive, give age 72 years

### MEDICAL CERTIFICATION

2D. DATE OF DEATH Aug. 9<sup>th</sup> 1946 at 130P  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 2<sup>nd</sup> 1946 to Aug. 9<sup>th</sup> 1946  
and that I last saw him alive on Aug. 9<sup>th</sup> 1946  
Immediate cause of death Stroke  
Due to Chronic Glomerulonephritis  
Due to  
Other conditions  
(Include pregnancy within 3 months of death)

### DURATION

1 week

9. Birthplace Germany  
(Town, county, and state)  
10. Usual occupation at home  
11. Industry or business Carl Schultze  
12. Name Carl Schultze  
13. Birthplace Germany  
14. Maiden name No. of Record  
15. Birthplace Germany  
16. Informant M. Gust Ernst Neuman  
Address R.D. #1, Salisbury, Md  
17. Buried Date thereof Aug 12<sup>th</sup> 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory St. Luke Kor Carter G. Md  
Location Hallway & G. Walter R. Williams  
18. Funeral director Salisbury Maryland  
Address 812 46  
19. (Date rec'd by registrar) 8/12/46 Registrar R. Roy Smith

Major findings of operations  
Date of op.  
Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.  
22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?  
23. SIGNATURE John H. Ycamar  
M. D. or other  
Address 238 Camden Ave Date signed Aug 11, 1946  
Salisbury

MARGIN RESERVED FOR BINDING

VS 415 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

INDEXED  
AUG 15 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH <sup>ec</sup>2411 N. Charles St., Baltimore <sup>950</sup>

## CERTIFICATE OF DEATH

Reg. Dist. No. 355

<b>1. PLACE OF DEATH:</b> County..... <u>Worcester</u> City or town..... <u>Ocean City</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... <u>Six(6) Months</u> Hospital, institution, or street address where death occurred: <u>9 North Baltimore Ave.</u> How long in hospital or institution?.....					<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State..... <u>Maryland</u> ..... County..... City or town..... <u>Baltimore, 7</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>5314 Wayne Ave.</u> (If rural, give LOCATION) 2.(c) If veteran, name war.....				
<b>3. (a) FULL NAME</b> <u>Edrei Uriah Sauble</u>					<b>3. (b) Social Security Number</b>				
<b>4. Sex</b> <u>M</u>		<b>5. Color or race</b> <u>W</u>		<b>6. (a) Single, married, widowed, or divorced</b> <u>Married</u>					
<b>6. (b) Name of husband or wife</b> <u>Ruth N.</u>					<b>8. (c) If alive, give age</b> <u>47</u> years				
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>August 21, 1881</u>					<b>8. AGE:</b> Years <u>64</u> Months <u>11</u> Days <u>14</u> If less than one day <u>2</u> hrs. min.				
<b>9. Birthplace</b> <u>Bookleysville</u> (Town, county, and state)					<b>10. Usual occupation</b> <u>Retired</u>				
<b>11. Industry or business</b> <u>Carpenter</u>					<b>12. Name</b> <u>Eli S. Sauble</u>				
<b>13. Birthplace</b> <u>Maryland</u>					<b>14. Maiden name</b> <u>Sarah Jane Shaver</u>				
<b>15. Birthplace</b> <u>Maryland</u>					<b>16. Informant</b> <u>Ruth N. Sauble</u> Address <u>9 North Balto. Ave., Ocean City, Md.</u>				
<b>17. Burial</b> (Burial, cremation, or removal. Which?) Date thereof <u>Aug. 7, 1946</u> (month) (day) (year) Cemetery or crematory <u>Meadowridge</u> Location <u>Baltimore, Maryland</u>					<b>18. Funeral director</b> <u>Hill &amp; Johnson</u> Address <u>Salisbury, Maryland</u>				
<b>19.</b> <u>8/4/46</u> 19 <u>46</u> (Date rec'd by registrar) Registrar <u>Helen F. Hayward</u>					<b>20. DATE OF DEATH</b> <u>4 August 1946</u> at <u>2 A</u> M <b>21. I CERTIFY</b> that death occurred on the date above stated; that I attended deceased from <u>1 July 1946</u> to <u>4 August 1946</u> and that I last saw him alive on <u>1 August 1946</u> Immediate cause of death <u>Coronary Thrombosis Acute</u> Due to <u>Hypertrophy of heart</u> Due to..... Other conditions <u>None</u> (Include pregnancy within 3 months of death) Major findings of operations <u>None</u> Date of op..... Autopsy results <u>No autopsy</u> PHYSICIAN: Please underline the cause to which death should be charged statistically.				
<b>22. VIOLENCE:</b> If death was due to external causes, fill in the following: Accident, suicide, or homicide <u>None</u> Date of..... Where did injury occur? (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of Injury Injured at work?					<b>23. SIGNATURE</b> <u>Eli S. Sauble</u> Address <u>Ocean City, Md.</u> Date signed <u>8/4/46</u>				

RECEIVED  
AUG 9 1946  
BUREAU V S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 952

## CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH: *Worcester*  
 County.....  
 City or town.....*Ocean City*  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? *21 days*  
 Hospital, institution, or street address where death occurred: *no*

How long in hospital or institution? *no*

3. (a) FULL NAME *Georgie Howell*

3. (b) Social Security Number

*Lost*

4. Sex *Female* 5. Color or race *coel* B. (a) Single, married, widowed, or divorced *widow*  
 6. (b) Name of husband or wife *Rangie Howell*  
 6. (c) If alive, give age *no* years  
 7. Birth date of deceased (mo., day, yr.) *about 1888*

8. AGE: Years *38 about* Months *—* Days *—* If less than one day *—* hrs. *—* min.

9. Birthplace *Whaleyville md*  
 (Town, county, and state)

10. Usual occupation *Housewife*

11. Industry or business *same as above*

12. Name *George Jareman*

13. Birthplace *Whaleyville*

14. Maiden name *Georgie Jareman*

15. Birthplace *Whaleyville*

16. Informant *Gertrude Armstrong*

Address *Berlin md*

17. *Burial* Date thereof *Aug 13-46*  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Evergreen*

Location *Berlin md*

18. Funeral director *James F. Stewart*

Address *Salisbury md*

19. *8-12* *46* *Helen L. Hayward*  
 (Date rec'd by registrar) (month) (day) (year) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State *Maryland* County *Worcester*  
 City or town *Berlin*  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. *no*  
 (If rural, give LOCATION)

2. (a) If veteran, name war *no*

## MEDICAL CERTIFICATION

20. DATE OF DEATH *Aug 9* 19 *46* at *2* P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19....., to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death *myocardial degeneration of heart*

Due to.....

Due to.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

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Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

23. SIGNATURE *John L. Riley Dep. Med Exam*  
 M. D. or other

Address *Shore Hill Md*

Date signed *8/9/46*

RECEIVED

AUG 14 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 82

## CERTIFICATE OF DEATH

Reg. Dist. No.

0846851

## 1. PLACE OF DEATH:

County Worcester  
 City or town Newark, md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? about 25 years  
 Hospital, institution, or street address where death occurred: no  
 How long in hospital or institution? no

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State MD County Worcester  
 City or town Newark, md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. no  
 (If rural, give LOCATION) no  
 2.(a) If veteran, name war no

## 3. (a) FULL NAME

Minnie E. Spence

## 3. (b) Social Security Number

no

4. Sex female 5. Color or race A.A. 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Harice Spence

7. Birth date of deceased (mo., day, yr.) Mar 7 about 1903 6.(c) If alive, give age 45 years

8. AGE: Years about 43 Months - Days - If less than one day - hrs. - min.

9. Birthplace Berlin, md.  
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Same as above

12. Name George Morris

13. Birthplace Berlin, md.

14. Maiden name Emma Tangle

15. Birthplace Berlin, md.

16. Informant Harice Spence

Address Newark, md.

17. Burial Date thereof Sept 1-1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Type

Location Berlin, md.

18. Funeral director James D. Stewart

Address Salisbury, md.

19. 9/1/46 Polay Smith  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 30 1946, at 2 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 2 1946, to Aug 30 1946, and that I last saw her alive on Aug 30 1946

Immediate cause of death Respiratory paralysis DURATION 2 Hr.

Due to Myocardial infarction 4 Hr.

Due to malignant Hypertension 1 year.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert L. LaMar, MD M. D. or other

Address Summit Hill Date signed 8/30/46

RECEIVED  
SEP 3 1946  
BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

## CERTIFICATE OF DEATH

Reg. Dist. No. 350

## 1. PLACE OF DEATH:

County.....*Worcester*  
 City or town.....*Pocomoke City*  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....*58 years*  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State.....*Maryland* County.....*Worcester*  
 City or town.....*Pocomoke City*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....*515 Young Street*  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

*Hester Jane Sturgis*

## 3. (b) Social Security Number

## 4. Sex

*Female*

## 5. Color or race

*Colored*

## 6. (a) Single, married, widowed, or divorced

*Married*

## 6. (b) Name of husband or wife

*Wesley Sturgis*

## 7. Birth date of deceased (mo., day, yr.)

*December 24, 1875*

## 6. (c) If alive, give age..... years

*68*

## 8. AGE:

Years

*70*

Months

*7*

Days

*24*

If less than one day

.....hrs. ....min.

## 9. Birthplace

*Somerset County, Maryland*  
(Town, county, and state)

## 10. Usual occupation

*Domestic*

## 11. Industry or business

*Private home*

## FATHER

## 12. Name

*Joseph Pittman*

## 13. Birthplace

*Somerset County, Md*

## MOTHER

## 14. Maiden name

*Eliza Beckett*

## 15. Birthplace

*Pocomoke City, Md*

## 16. Informant

*Mrs. Thos. R. Doleffe*

## Address

*6th Street, Pocomoke City, Md*

## 17.

(Burial, cremation, or removal) Which?

Date thereof

(month) (day) (year)

## Cemetery or crematory

*Burial Halls Hill Cemetery*

## Location

*Pocomoke City, Md*

## 18. Funeral director

*S. Harrison Bradshaw*

## Address

*Pocomoke City, Md*

## 19.

(Date rec'd by registrar)

*Aug 21, 1946 Anne E. White*

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

*Aug 18, 1946, at 3:15 PM*

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*July 31, 1946, to Aug 8, 1946*and that I last saw him alive on *Aug 8, 1946*

## Immediate cause of death

*Coronary occlusion*

## DURATION

*Sudden death*

## Due to

*Coronary insufficiency, S.K.*

## \*Due to

*Hypertension*

## Other conditions

*Summit years*

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op. ....

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of .....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

*N. E. Sartorius MD*

M. D. or other

Address

*Pocomoke City, Md*Date signed *8/21/46*

AUG 24 1946  
BUREAU V.S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 910

## CERTIFICATE OF DEATH

Reg. Dist. No. 355

### 1. PLACE OF DEATH:

County Worcester

City or town Berlin  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County WORCESTER

City or town Berlin  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

William Edward Townsend

### 3. (b) Social Security Number

4. Sex male

5. Color or race white

6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Hettie L. Townsend

6.(c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) August 23, 1867

8. AGE: Years 78 Months 11 Days 26 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Newark W. Va. Md.  
(Town, county, and state)

10. Usual occupation Lumber dealer

11. Industry or business \_\_\_\_\_

12. Name Josiah Townsend

13. Birthplace Md.

14. Maiden name Mary Vandome

15. Birthplace Md.

16. Informant Mrs. W. E. Townsend

Address Berlin, Md.

17. Burial Date thereof 8/21/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Evergreen

Location Berlin Md.

18. Funeral director Anna R. Burban

Address Berlin Md.

19. 8-20 19 46 Helen F. Hayward  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 19 Aug 19 46, at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 Aug 19 46, to 19 Aug 19 46, and that I last saw him alive on 19 Aug 19 46.

Immediate cause of death Cerebral

thrombosis

#### DURATION

4 days

Due to Hypertensive Cordid

Vascular Disease

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations None

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of \_\_\_\_\_

Where did injury occur? None  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) None

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Elmer P. McE...

Address Reese City Md. Date signed 20 Aug 46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
AUG 22 1945  
BUREAU V B